

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

## DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-63-001528  
358 STATE FILE NUMBER

DO NOT WRITE  
ON THIS STUD

AMENDED

Registration District No. 149 Primary Registration District No. 1002 Registrar's No.

**FILED FEB 6 1963**

|  |  |   |  |
|--|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Jackson</b>  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission)<br>a. STATE <b>Missouri</b> b. COUNTY <b>Jackson</b>                    |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <b>Kansas City,</b>                 |  | c. CITY OR TOWN <b>Kansas City,</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>   |  |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <b>4032 Bellefontaine</b> |  | d. STREET ADDRESS (If outside, give location)<br><b>4032 Bellefontaine</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |  |

|  |                                  |   |   |   |   |
|--|----------------------------------|---|---|---|---|
| 3. NAME OF DECEASED<br>(Type or print) First Middle Last<br><b>Douglas L. Davis</b>                            |                                  |   | 4. DATE OF DEATH<br>Month Day Year<br><b>January 19, 1963</b> |   |   |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>Negro</b> | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>3-3-90</b>                             | 9. AGE (last birthday)<br><b>73</b>                                   | IF UNDER 1 YEAR<br>Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Minister</b> |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Baptist Church</b>  |   | 11. BIRTHPLACE (City and state or country)<br><b>Sartartia, Miss.</b> |   |
| 12. CITIZEN OF WHAT COUNTRY<br><b>U.S.A.</b>   |                                  | 13a. FATHER'S NAME<br><b>unknown</b>  |   | 13b. MOTHER'S MAIDEN NAME<br><b>unknown</b>                           |   |
| 14. NAME OF HUSBAND OR WIFE<br><b>Oza Lee Davis</b>  |                                  | 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes, give war or dates of)<br><b>Yes WW # 1</b>                                    |   |   |   |
| 16. SOCIAL SECURITY NO.<br><b>01</b>   |                                  | 17. INFORMANT<br>Address<br><b>Oza Lee Davis, K. C., Mo.</b>  |   |   |   |

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|--|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Arteriosclerosis</b><br>Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.<br>DUE TO (b)<br>DUE TO (c) |  | INTERVAL BETWEEN ONSET AND DEATH   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)<br><b>Senility</b>   |  | PART III. If deceased was female was there a pregnancy in last 90 days.<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |

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|--|---|--|--|
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  | 20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/> | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) |  |
| 20c. TIME OF INJURY<br>Hour a.m. p.m.<br>Month, Day, Year  | 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>    | 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)     | 20f. CITY, TOWN, OR LOCATION<br>COUNTY STATE                             |
| 21. I attended the deceased from _____, to _____ and last saw her/him alive on _____<br>Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated. |   |  |  |
| 22a. SIGNATURE (Degree or title)<br><b>M. M. Tillman M.D. Deputy Coroner</b>   |   | 22b. ADDRESS<br><b>1618 Lydia Ave.</b>   | 22c. DATE SIGNED<br><b>1/21/63</b> (State)                               |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Removal</b>  | 23b. DATE<br><b>1-23-63</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>National Cemetery</b>                               | 23d. LOCATION (City, town, or county)<br><b>Fort Leavenworth, Kansas</b> |
| 24. FUNERAL DIRECTOR<br>ADDRESS<br><b>Mrs. Meek's Mortuary, K. C., Mo.</b>   |   | 25. DATE RECD. BY LOCAL REG.<br><b>1-21-63</b>   | 26. REGISTRAR'S SIGNATURE<br><b>Pruth Long</b>                           |

(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK  
OR  
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

BY AFFIDAVIT OF

M. M. Tillman MEDICAL CERTIFICATION

VS 300  
Rev. 4/59

DATE AMENDED

VS 300  
Rev. 4/59

VS 300  
Rev. 4/59

VS 300  
Rev. 4/59

VS 300  
Rev. 4/59

VS 300  
Rev. 4/59

VS 300  
Rev. 4/59

VS 300  
Rev. 4/59

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STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Millard B. Perkins

Licensed Embalmer No. 5013

P. O. Address 15 C. M. 8

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.